



## **NURSING PRACTICE COMMITTEE MEETING**

### **AGENDA**

**DCA Headquarters  
1625 N. Market Blvd  
Hearing Room S-102  
Sacramento, CA 95834**

**March 10, 2011**

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**Thursday, March 10, 2011 – 1:30 pm – 2:30 pm**

**10.0 Review and Approve Minutes**

Ø January 5, 2011

**10.1 Information Only: Nothing Left Behind, speakers Shelley A. Carroll, MSN, RN, CNOR (e) and Jill Stanfield, RN, CNOR, CRNFA**

**10.2 Registered Nurse Advisories**

- Abandonment of Patients
- Nursing Student Workers
- Reproductive Privacy Act
- The RN as the First Assistant to the Surgeon

**10.3 Nurse Practitioners Practice Advisories**

- Clinic's Eligible for Licensure
- General Information: Nurse Practitioner Practice
- Nurse Practitioner in Long-Term Care Settings

**10.4 Public Comment for Items Not on the Agenda**

**NOTICE:**

All times are approximate and subject to change. Items may be taken out of order to maintain a quorum, accommodate a speaker, or for convenience. The meeting may be canceled without notice. For verification of the meeting, call (916) 574-7600 or access the Board's Web Site at <http://www.rn.ca.gov>. Action may be taken on any item listed on this agenda, including information only items.

Public comments will be taken on agenda items at the time the item is heard. Total time allocated for public comment may be limited.

The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting the Administration Unit at

(916) 574-7600 or email [webmasterbrn@dca.ca.gov](mailto:webmasterbrn@dca.ca.gov) or send a written request to the Board of Registered Nursing Office at 1625 North Market #N-217, Sacramento, CA 95834. (Hearing impaired: California Relay Service: TDD phone # (916) 322-1700). Providing your request at least five (5) business days before the meeting will help to ensure the availability of the requested accommodation.

Board members who are not members of this committee may attend meetings as observers only, and may not participate or vote. Action may be taken on any item listed on this agenda, including information only items. Items may be taken out of order for convenience, to accommodate speakers, or maintain a quorum.



**Draft**

## **NURSING PRACTICE COMMITTEE MEETING MEETING MINUTES**

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**DATE:** January 5, 2011

**TIME:** 1:30 PM

**LOCATION:** Hilton San Diego Mission Valley  
901 Camino del Rio South  
San Diego, CA 92108  
Phone: 510-622-2564

**COMMITTEE MEMBERS PRESENT:** Kathrine Ware MSN, RN, ANP-C Chairperson  
Catherine M. Todero, PhD, RN

### **10.0 Review and Approve Minutes:**

- Ø May 18, 2010
- July 13, 2010
- September 22, 2010
- November 16, 2010

MSC : Ware/Todero moved to accept the above meeting minutes with typographical corrections.

### **10.1 Report on the Goals and Objectives 2010**

Each year the Practice Committee reviews the goal achievement through committee activities and staff activities related to the goals. Report for Goals and Objectives 2010 attached. The Goals and Objectives for 2011 to continue as presented in the attachment, no additions or deletions by the committee. Committee member stated the 2011 Goals and Objective are pertinent to the activities of the committee.

### **10.2 Registered Nurse Advisories**

Directions to locate registered nurse advisories at [www.rn.ca.gov](http://www.rn.ca.gov). When using the BRN home page, locate the cursor on left hand side of page, titled "Practice Information." Then locate the cursor over "registered nurse" for a listing of advisories.

The liaison to the Practice Committee with assistance from NEC staff have been reviewing and updating BRN advisories utilizing the California Nursing Practice Act with Regulations and Related

Statutes, 2010 Edition and California Law and also found at [www.leginfo.ca.gov](http://www.leginfo.ca.gov) as a resource. Advisories not related to the Nursing Practice Act, NPA, are researched for currency and best practice in nursing textbooks, periodicals and journals and standard setting organizations.

- Abandonment of Patients
- An Explanation of the Scope of RN Practice Including Standardized Procedures
- Complementary and Alternative Therapies in Registered Nursing Practice
- Nursing Student Workers
- RN Tele-Nursing and Telephone Triage
- Reproductive Privacy Act
- Standardized Procedures Guidelines
- Standards of Competent Performance
- Supervisor's Responsibility
- The RN as the First Assistant to the Surgeon

MSC: Ware/Todero: Committee members moved to accepted the above updated advisories. See attachments.

With Board approval, the following advisories will be posted to the BRN website:

### **10.3 Public Comment for Items Not on the Agenda**

Public comment by Monica Weisbrick RN, member of Operating Room Nursing Council wished to make the committee aware of the new AORN 2010 Recommended Practice for Retained Surgical Items. "Nothing Left Behind" is a National Surgical Patient-Safety Project to prevent retained surgical items sponsored by a physician at UCSF. Some of the major changes for "retained surgical items" new equipment changes, bar codes, radiological tags. Suggestion is to review the changes in the workplace for retained foreign bodies where surgery or surgical type procedures are taking place.

Submitted by:

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Janette E. Wackerly, MBA, RN  
Liaison, Nursing Education Consultant

Approved by:

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Kathrine Ware, MSN, RN, ANP-C  
Chairperson

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Louise Bailey, M.Ed, RN, Interim Executive Officer

## **NURSING PRACTICE COMMITTEE MEETING**

### **MEETING MINUTES**

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**DATE:** May 18, 2010

**TIME:** 3:00 PM – 4:00 PM

**LOCATION:** Hilton Orange County  
3050 Bristol Street  
Costa Mesa, CA 92626  
Phone: (916) 574-7600  
Fax: (916) 574-7700

#### **COMMITTEE MEMBERS PRESENT:**

Kathrine Ware, MSN, RN, ANP-C Chair  
Nancy Beecham, BS, RNC  
Catherine Todero, PhD, RN

#### **OTHERS PRESENT:**

Janette Wackerly, MBA, RN NEC Liaison  
Louise Bailey, Interim Executive Officer  
Geri Nibbs, NEC  
Miyo Minato, NEC  
Kay Weinkam, NEC  
Katie Daugherty, NEC  
Heidi Goodman, Asst EO  
Louisa Gomez, Program Manager  
Leslie Moody, NEC  
Shelly Ward, NEC  
Judith Martin-Holland, Associate Dean UCSF  
Nancy Spavan  
Kelly Green, CNA  
Jill Omstead, NP, CANP  
Trisha Hunter, RN, ANA/C  
Julie Campbell-Warnock, Research Specialist

Kathrine Ware, Chair opened the meeting shortly after 4:00 pm. and had the committee members introduce themselves.

## **11.0 Review and Approve:**

➤ May 18, 2010

MSC: Toder/Beecham that the Committee approve minutes from February 24, 2010.

### **11.1 APRN Consensus: Issues related to the Regulatory Model by Colleen Keenan PhD, CANP Board of Director, Chair Practice Committee**

Colleen Keenan PhD, RN Chair Practice Committee, California Association of Nurse Practitioners gave a presentation to the Committee on the APRN (Advanced Practice Registered Nurse) Consensus.

Introduced in 2008, the APRN Consensus Regulatory Model is a nationally developed process designed to ensure high quality patient care and safety delivered by advanced practice nurses. Four dimensions of regulation model (LACE) include education and program accreditation, individual APRN national certification and licensure within an APRN role and population. The presentation objectives included:

- Review the components of the APRN Consensus Regulatory Model from a *Nurse Practitioner* Perspective
- Present the national timeline related to planned implementation of the LACE framework
- Provide opportunities for discussion concerning application of the regulatory model in California.

For information: Nursing Practice Committee January 15, 2009 and Draft Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education June 18, 2008.

### **11.2 Barriers to Nursing Student Clinical Practice:**

Kathrine Ware, Chairperson, requested persons in the audience to report on their experience with any barriers to nursing student clinical practice.

Comments made during Nursing Practice Committee Meeting on May 18, 2010, are as follows:

Judy Martin-Holland, Associate Dean, UCSF

Barriers to Nursing Student Clinical Practice:

- Electronic Medical Record (EMR), Pyxis (Medications), and OmiCell (Supplies) have created a natural impediment to nursing student experiences obtaining and passing medications. After much discussion and negotiating, limited access to charting and medication has been obtain in many of the clinical settings for students, but the process of obtaining access and using the limited access provided is highly laborious.
- Pediatric and psychiatric settings – many require the student have a facility RN at the student's side during medication administration. The Clinical Faculty or Clinical Instructor in some instances is not enough, facilities require a bedside nurse. This can

represent a perception of time drain for RNs who then in some cases refuse to work with patients for which students have been assigned.

- Pharmacists are putting policies in place to restrict student access to medications and administration of medication. A few pharmacist colleagues have reported receiving information from the "pharmacy board" (be it the CA Pharmacy Bd or a professional association – unclear), but they are saying the Prof Code 2729 document previously distributed by Ruth Ann Terry, is not strong enough evidence to substantiate student access to medication.
- Hospitals and medical centers are frequently canceling student rotations/clinical experiences, sometimes with less than a day notice, when notified of a Joint Commission or CMS visit.
- Students must complete multiple modules and other pre-clinical rotation facility-based learning activities before setting foot in each clinical facility. The majority of these modules are repetitive of information/activities required by the School and other area facilities. Completion of these modules/activities take an average of 8-10 hours per setting, per student. Students moving from a pediatric rotation to a psych rotation, to a med-surg rotation in one quarter, may spend up to 30 hours completing repetitious modules (HIPPA, Handwashing, Falls, Verbal Orders, etc.). This information is above and beyond facility specific responses such as what to do in case of fire (where to call, how to respond), Code designations (blue, patient out of control, etc.).
- The Joint Commission has a document guiding facilities who have volunteer and contract personnel in their facilities. Some facilities consider nursing students in this category of "visitor" in the facility. The document greatly limits sharing patient information and student involvement with patient care. Facilities who stringently use this document limit students to observatory roles limiting student-patient interaction.
- Additionally, on the Advanced Practice side of our education programs, pharmacists limit licensed Registered Nurses who are in a graduate advanced practice program to have access to medications or to administer medications.
- Licensed RNs in a graduate program are still not allowed access to EMR.
- Liability concerns are used to control student-patient interactions for students in the advanced practice program. We're told the students "must be supervised at all times".
- Advanced practice nurses report patient volume expectations cannot be maintained while a student is being precepted, so they restrict access to our students.
- Liability language required by the UC's limits midwifery student ability to experience home and other alternative birth locations.

Dr. Nancy Cowen MS.EdD Director at Chabot College was unable to attend the meeting and requested to present the findings of the northern ADN Directors at the July 13, 2010 meeting.

Dr. Nancy Cowen MS, EdD; RN Director at Chabot Colleges and president of the Northern California Associate Degree Nursing Director Group will provide survey information on items of concern. Vicky Maryatt, RN MSN Director American River College and Roz Hartman MSN, RN Director at College of Marin produced the survey with results which will be brought to the committee meeting.

Northern Associate Degree Nursing Programs are experiencing difficulty with aspects of nursing student clinical affiliations in acute care and in some instances inability of nursing students to perform glucometer testing, access to medication including narcotics, access to the electronic medical record, and limiting Bar Coding Medication Administration. Faculties are experiencing changes in acute care where nursing student learning opportunities have been declining in the hospitals.

**11.3 Public Comment for Items Not on the Agenda**

**11.4 Open Forum** No public comment was made.

Submitted by:

Janette Wackerly RN  
Janette E. Wackerly, MBA, RN  
Liaison, Nursing Education Consultant

Approved by:

Kathrine Ware MSN, RN, ANP-C  
Kathrine Ware, MSN, RN, ANP-C  
Chairperson

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**Louise R. Bailey, M.Ed., RN Interim Executive Officer**



**NURSING PRACTICE COMMITTEE MEETING**  
**MEETING MINUTES**

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**DATE:** July 13, 2010

**TIME:** 1:00 PM

**LOCATION:** DCA Headquarters  
1625 North Market Blvd  
Hearing Room S-102  
Sacramento, CA 95834

**COMMITTEE MEMBERS PRESENT:**

Kathrine Ware MSN, RN, ANP-C Chair  
Erin Niemela

**OTHERS PRESENT:**

Janette Wackerly, MBA, RN, NEC Liaison  
Louise Bailey, M.Ed., RN, Interim Executive Officer  
Heidi Goodman, Assistant Executive Officer, BRN  
Badrieh Caraway, RN, NEC  
Geri Nibbs, RN, NEC  
Katie Daugherty, RN, NEC  
Kay Weinkam, RN, NEC  
Kelly McHan, RN, NEC  
Miyo Minato, RN, NEC  
Shelly Ward RN, NEC  
Leslie Moody RN, NEC  
Pat McFarland EO, ACNL  
Bobbie Pierce, Licensing  
Crystal Silva, Licensing  
Nancy Spradling, CSNO  
Candace Campbell, ANA/C  
Kelly Green, CNA  
Myrna Allen, ANA/C  
Vickie Maryatt, RN, MSN, Director American River College  
Nancy Cowne, MS, EdD, Emeritus Director  
April Reed, Samuel Merritt University  
Sue Starck, Carrington College  
Grace Corse, SEIU Nurse Alliance

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Kathrine Ware, Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

**9.0 Review and Approve Minutes:**

- July 13, 2010
- May 18, 2010

**MSC:** Minutes were held over to the next committee meeting for approval.

**9.1 BRN Study of California RNs on Probation 2004-2005**

BRN staff is working with Joanne Spetz and other research staff from the University of California, San Francisco Center for the Health Professions to complete a report on a study of California RNs who either began or extended probation in 2004 or 2005, which totals approximately 275 cases. This study is based on one published in March 2009 in the American Journal of Nursing. The National Council of State Boards of Nursing (NCSBN) worked with six boards of nursing to explore and evaluate what factors might affect the outcomes of remediation, including the likelihood of recidivism. A 29-item data extraction template was used to obtain data on the characteristics of the disciplined nurses, their employment settings, board actions, and remediation outcomes. A control group of nurses who had not been disciplined were used to compare data against the disciplined nurses.

BRN staff began collecting data on the California RNs in October 2009 using a modified version of the 29-item data collection instrument. Some additional data elements were collected which are outlined in the attached study overview. The collected data was provided to UCSF in May 2010 and they have begun working on the data entry and analysis. The final report is estimated to be completed in late October or early November 2010.

**9.2 Barriers to Nursing Student Clinical Practice**

Dr Nancy Cowen MS, EdD, RN Director at Chabot Colleges and President of the Northern California Associate Degree Nursing Director Group provided survey information on items of concern: Cynthia Harrison, RN, MSN, Director Mission College, Vicky Maryatt, RN MSN Director American River College and Roz Hartman MSN, RN Director at College of Marin were involved with producing the survey tool.

In spring 2010 nursing programs were notified of loss of their clinical placements for students in acute care units, OB, Mental Health, Pediatrics, Medical Surgical and Geriatrics. The individual colleges and the number of students affected by clinical placement loss will be discussed as demonstrated in the survey. Clinical placements for fall 2010 have not been confirmed.

Northern Associate Degree Nursing Programs are experiencing difficulty with aspects of nursing student clinical affiliations in acute care and in some instances inability of nursing students to perform glucometer testing, access to medication including routine medications, IV administration and narcotics, access to the electronic medical record, and limiting Bar

Coding Medication Administration. Faculties are experiencing changes in acute care where nursing student learning opportunities have been declining in some hospitals.

### 9.3 Report CALNOC Conference: The Global Reach of Nursing Quality

Collaborative Alliance for Nursing Outcomes, CALNOC, June 23-24, 2010 Conference "The Global Reach of Nursing Quality" was held at the South San Francisco Conference Center.

Keynote address by Craig Clapper, PE, CMO/OE, founding partner and COO Health Performance Improvement spoke about Making Reliability a Reality: Quality Interest in the Patient Safety Culture.

Mary Foley PhD, RN Assistant Director, Center for Research and Innovation in Patient Care, UCSF School of Nursing, addressed CALNOC Medication Administration Accuracy through the art and logistics of naïve observation, planning data collection, leveraging the observational moment, drilling down on distraction, documentation and patient education, using the CALNOC measure to evaluate practice and EHR innovations.

Nancy Donaldson, DNSc, RN FAAN, co-principle investigator, CALNOC, Director, Center for Nursing and Research and Innovation, UCSF School of Nursing, presented Medication Administration Accuracy, the link between safe practices and medical administration errors.

Medication Administration Accuracy a local project that illuminates the problems and interventions in the nurse sensitive factors in medication administration. Seven hospitals from the San Francisco Bay Area participated in an 18 month-long Integrated Nurse Leadership Program, which was designed to improve reliability of medication administration and used the CALNOC Medication Administration Accuracy Tool.

Pam Wells RN, MSN, Vice President and Chief Nursing Officer, Lucille Packard Children's Hospital, Palo Alto, CA presented exemplar-using the CALNOC Medication Administration Accuracy Measure to explore the impact of electronic health record implementation.

**CALNOC** – Mission is to advance global patient care safety, outcomes and performance measurement efforts by: Leveraging a dynamic nursing outcomes database and reporting system; providing actionable data to guide decision making performance improvement, and public policy; conducting research to optimize patient care excellence; building leadership expertise in the use of practice-based evidence.

The following people made a comment:

Victoria Marriot, Director of American River College

Nancy Cowan Pinro, Director of Chabot College

Pat McFarland, Association of California Nurse Leaders

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#### 9.4 Public Comment for Items Not on the Agenda

No public comment was made.

Submitted by:

Janette Wackerly RN  
Janette E. Wackerly, MBA, RN  
Liaison, Nursing Education Consultant

Approved by:

Kathrine Ware MSN, RN, ANP-C  
Kathrine Ware, MSN, RN, ANP-C  
Chairperson

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**Louise R. Bailey, M.Ed., RN Interim Executive Officer**



**NURSING PRACTICE COMMITTEE MEETING**  
**MEETING MINUTES**

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**DATE:** September 22, 2010  
**TIME:** 1:00 PM  
**LOCATION:** Hilton San Diego Mission Valley  
901 Camino del Rio South  
San Diego, CA 92108

**COMMITTEE MEMBERS PRESENT:**

Nancy Beecham, RN-BC acting Chair  
Erin Niemela

**OTHERS PRESENT:** Janette Wackerly, MBA, RN, NEC Liaison, Louise Bailey, M.Ed., RN, Interim Executive Officer, Maria Bedroni, MSN, RN SNEC, Heidi Goodman, Assistant Executive Officer, BRN, Badrieh Caraway, RN, NEC, Geri Nibbs, RN, NEC, Katie Daugherty, RN, NEC, Kay Weinkam, RN, NEC, Kelly McHan, RN, NEC, Miyo Minato, RN, NEC, Shelly Ward RN, NEC, Leslie Moody RN, NEC, Carol Mackay, MN, RN, NEC, Bobbie Pierce, Licensing Manager, Kathy Hodge Enforcement, Julie Campbell-Warnock Research Program Specialist

Nancy Beecham, acting Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

**10.0 Review and Approve Minutes:**

- September 22, 2010
- July 13, 2010
- May 18, 2010

**MSC:** Minutes were held over to the next committee meeting for approval.

**10.1 BRN survey of California Nurse Practitioners, Certified Nurse-Midwives and Clinical Nurse Specialists**

Julie Campbell-Warnock Research Program Specialist gave the following report.

The BRN is working with Joanne Spetz and other research staff from the University of California San Francisco (UCSF), Center for the Health Professions to complete a survey of California Nurse Practitioners, Certified Nurse-Midwives and Clinical Nurse Specialists. The purpose of the survey is to learn information about demographics,

education, employment, practice and standardized procedure use from these advanced practice nurses in California. There has not been much data collected from these advanced practice registered nurses nationally or in other states so there is interest nationally in the data that will be collected.

On June 30, 2010, the BRN had a brainstorming meeting/conference call with UCSF staff to discuss information to collect, ideas for the best way to collect the data and determine potential subject matter experts to further assist in survey development. UCSF then developed two sample surveys, one for Nurse Practitioners and Certified Nurse-Midwives and one for Clinical Nurse Specialists. There are some overlapping questions between the two surveys and some unique questions to target information from each specific advanced practice specialty area. On August 23, 2010, the BRN and UCSF staff had another meeting/conference call with subject matter experts representing the different advanced practice areas to refine the survey instruments. The subject matter experts were:

- Ann Mayo, Professor at Hahn School of Nursing and Health Science in San Diego representing Clinical Nurse Specialists
- Colleen Keenan, Interim Director of Nurse Practitioner Program at UCLA School of Nursing, representing Nurse Practitioners
- BJ Snell, Faculty Director at California State University, Fullerton, representing Certified Nurse-Midwives (she was not able to join the call but it is hoped she can provide feedback via e-mail).

The surveys are now being finalized and field tested, and are expected to be sent to a total sample of 5,000 to 6,000 California registered nurses certified in these advanced practice areas in mid-October. Data from the survey will be analyzed and a report completed by UCSF, discussing the findings, is expected by June 2011.

## 10.2 Public Comment for Items Not on the Agenda

No Public input.

Submitted by:

Janette Wackerly RN

Janette E. Wackerly, MBA, RN  
Liaison, Nursing Education Consultant

Approved by:

Kathrine Ware MSN, RN, ANP-C

Kathrine Ware, MSN, RN, ANP-C  
Chairperson

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**Louise R. Bailey, M.Ed., RN Interim Executive Officer**



**NURSING PRACTICE COMMITTEE MEETING**  
**MEETING MINUTES**

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**DATE:** November 16, 2010

**TIME:** 1:30 PM

**LOCATION:** Department of General Services  
Elihu Harris State Building  
1515 Clay Street  
Conference Center, 2<sup>nd</sup> Floor  
Oakland, CA 94612  
Phone: 510-622-2564

**COMMITTEE MEMBERS PRESENT:**

Nancy Beecham, RN-BC acting Chair  
Erin Niemela

**OTHERS PRESENT:** Janette Wackerly, MBA, RN, NEC Liaison, Louise Bailey, M.Ed., RN, Interim Executive Officer, Maria Bedroni, MSN, RN SNEC, Heidi Goodman, Assistant Executive Officer, BRN, Badrieh Caraway, RN, NEC, Geri Nibbs, RN, NEC, Katie Daugherty, RN, NEC, Kay Weinkam, RN, NEC, Kelly McHan, RN, NEC, Miyo Minato, RN, NEC, Shelly Ward RN, NEC, Leslie Moody RN, NEC, Carol Mackay, MN, RN, NEC, Bobbie Pierce, Licensing Manager, Kathy Hodge Enforcement, Julie Campbell-Warnock Research Program Specialist

Nancy Beecham, acting Chair opened the meeting shortly after 1:00 pm and the committee members introduced themselves.

**10.0 Review and Approve Minutes:**

- November 16, 2010
- September 22, 2010
- July 13, 2010
- May 18, 2010

**MSC:** Minutes were held over to the next committee meeting for approval.

**10.1 A Report on the Institute of Medicine and Robert Wood Johnson Foundation Initiative on the Future of Nursing by Liana Orsolini-Hain, Ph.D., RN, CCRN, Committee Member**

Dr. Liana M. Hain, Ph.D., is a committee member on the Robert Wood Johnson Foundation Initiative on the Future of Nursing. Dr. Hain is a full-time tenure track instructor at City College of San Francisco. She has more than 16 years of experience in associate's degree nursing education.

The following is an excerpt from the free summary, titled "The Future of Nursing: Leading Change, Advancing Health". The Committee's charge is to examine and produce recommendations related to the following issues, with the goal of identifying vital roles for nurses in designing and implementing a more effective and efficient health care system:

- Reconceptualizing the role of nurses within the context of the entire workforce, the shortage, societal issues, and current and future technology; and
- Expanding nursing faculty, increasing the capacity of nursing schools, and redesigning nursing education to assure that it can produce an adequate number of well prepared nurses able to meet current and future health care demands; and
- Examining innovative solutions related to health care delivery and health professional education focusing on nursing and delivery of nursing services; and
- Attracting and retaining well prepared nurses in multiple care settings, including acute, ambulatory, primary care, long term care, community and public health.

The link to the summary can be found at:

[http://www.nap.edu/nap-cgi/report.cgi?record\\_id=12956&type=pdfxsum](http://www.nap.edu/nap-cgi/report.cgi?record_id=12956&type=pdfxsum)

## 10.2 Registered Nurse Advisories

- Abuse Reporting Requirements
- Background Checks for Student Clinical Placement
- California Nursing Practice Act
- Complaint Disclosure Policy
- Continuing Education for License Renewal
- Good Samaritan
- Interim Permittee
- Information About Medical Assistant
- License Information
- Nurse Practitioners & Nurse-Midwives - Supervision of Medical Assistants
- Residential Care for the Elderly Employee, RCFE, Training for Self-Administration of Medication
- Unlicensed Assistive Personnel
- Use of Title: Registered Nurse and Name Tags

## 10.3 Public Comment for Items Not on the Agenda

Submitted by:

Janette Wackerly, RN  
Janette E. Wackerly, MBA, RN  
Liaison, Nursing Education Consultant

Approved by:

Kathrine Ware, MSN, RN, ANP-C  
Kathrine Ware, MSN, RN, ANP-C  
Chairperson

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.1

**DATE:** March 10, 2011

**ACTION REQUESTED:** Information only: “Nothing Left Behind” speakers Shelly A Carroll, MSN, CNOR (e) and Jill Stanfield, RN, CNOR, CRNFA

**REQUESTED BY:** Janette Wackerly, MBA, RN, NEC  
Liaison Practice Committee

**BACKGROUND:**

At the January 5, 2011 Practice Committee meeting at the public comment for items not on the agenda a representative of Operating Room Nursing Council suggested the committee be made aware of the new AORN 2010 Recommended Practice for Retained Surgical Items. Also of interest is “Nothing Left Behind” a National Surgical Patient-Safety Project to prevent retained surgical items sponsored by a physician at University California San Francisco.

The committee liaison was contacted by the Operating Room Nursing Council who proposed two members who would present information on current safety issues and cutting edge technology related patient safety in the operating environment.

**Nothing Left Behind** A National Surgical Patient-Safety Project to Prevent Retained Surgical Items, Verna C Gibbs M.D. Director, Nothing Left Behind, Professor Clinical Surgery UCSF, Staff Surgeon, SFVAMC.

Perioperative Standards and Recommended Practices (July 2010). Recommended practice for sponge, sharp, and instrument counts providing guidance to perioperative registered nurses in preventing retained surgical items in patients undergoing surgical and other invasive procedures. [www.aorn.org/psrp](http://www.aorn.org/psrp)

**NEXT STEPS:** Board

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686

**Patient safety**

## Preventing retained items: Time to consider technology?

**T**echnology is starting to take its place as a supplement to manual counts in the effort to prevent retained surgical items (RSIs). RSIs persist despite the emphasis many ORs have placed on tightening their manual counting methods. Recent reports from California are an example of the challenge ORs are up against (sidebar, p 18).

Though rare, RSIs take a heavy toll. Patients with retained items had a rate of death 2.14% higher than controls, excess hospital stays of 2.08 days, and excess costs of \$13,315, in a report by Zhan et al. They also increase liability costs.

Four companies now offer technologies to help in accounting for instruments and sponges. The newest, ORLocate, which entered the market in August 2010, is the first that can account for instruments. The other companies are upgrading their systems.

### Role for technology

A role for technology is being recognized in the literature and professional guidelines.

The Mayo Clinic, examining RSIs that occurred in its organization between 2003 and 2006, concluded that manual counting was unreliable as the primary means for avoiding RSIs and that investigating new technologies for achieving reliable counts is warranted (Cima et al, 2008).

AORN's new "Recommended practices for the prevention of retained surgical items" say that adjunct technologies may be considered to supplement manual counts, in addition to improving manual counting methods. The recommendations advocate a multidisciplinary approach to accounting for soft goods, sharps, and instruments plus standardized measures for counting and addressing count discrepancies.

An expert on RSI prevention, surgeon Verna Gibbs, MD, advises caution when considering technology.

"Technology adds another layer to already complex OR systems," she observes. "And technology requires human interface and interaction, which invite new opportunities for error. We also haven't seen how all the new developments will actually work in OR environments."

She says sponges have been retained with the new systems, "because humans operate the technology."

"Technology is not the answer but can assist with a difficult and persistent problem. It is up to hospitals to look at all the solutions that are out there and find what will work best for them."

Technology is also expensive. Each technology has sponges that are unique to its system and provide the companies with a continuing source of revenue. Once a hospital buys one company's sponges, it can't easily change to another system, Dr Gibbs points out.



Dr Gibbs, developer of the NoThing Left Behind campaign for RSI prevention ([www.nothingleftbehind.org](http://www.nothingleftbehind.org)), is professor of clinical surgery at the University of California, San Francisco, and a surgeon at the San Francisco Veterans Affairs Medical Center. She has been testing a refined manual counting method, called Sponge ACCOUNTING, which she says is coming up on a year of experience in 40 hospitals with no retained items reported.

### **Technology update**

Here's an update on the 4 companies that have Food and Drug Administration (FDA) clearance for their counting/detection systems.

The systems perform 3 basic types of functions: count sponges, detect sponges, or count and detect sponges and instruments.

### ***Counting and detecting instruments***

As the newest technology, ORLocate ([www.orldocate.com](http://www.orldocate.com)) counts, tracks, and monitors both surgical instruments and sponges in the OR using radiofrequency identification (RFID).

Each instrument and sponge is tagged with an RFID chip, giving the item a unique identity that tells not only where the item is but which item it is. The system confirms that counts are correct or incorrect, and if a sponge or instrument is missing, which one it is.

The RFID chip, the size of a small hearing aid battery, comes embedded in sterile surgical sponges and can be laser-welded in a ring to existing instruments. A flat surface area of at least 3 mm is needed to attach the chip.

The system also requires trays with detecting antennas for the Mayo stand and back table as well as a kick bucket with antenna, which can read how many and what kind of sponges or instruments are placed on or in them.

Dr Gibbs terms as "revolutionary" the company's ability to attach to instruments an RFID chip that can withstand sterilization.

ORLocate's general manager, Donald Mudd, says a common question the company receives is, "How do you know the chip won't fall off in the sterilizer?" He says the company's laboratory testing shows there have been over a thousand cycles of sterilization of these instruments without failures. "The instrument will have to be replaced before the chip," Mudd says.

The system costs \$100,000 per OR, which could be reduced to \$70,000, depending on the number of ORs. The company has a mobile lab for retrofitting existing instruments. If a hospital buys 5 OR systems, the company will tag 1,000 instruments at no charge; if 10 systems are purchased, 2,000 instruments will be tagged at no charge. Additional instruments are tagged for a nominal price.

ORLocate expects to pilot its system in January 2011.

### ***Asset management system***

ORLocate offers an additional platform for use as an asset management system in sterile processing departments (SPD). Dr Gibbs notes this is a unique attribute of this technology. Because each instrument with a chip has a unique identity, the system can be used to determine which instruments are in which trays and to keep track of instruments needing repair. If an instrument is missing, the system can tell which one. The system can also show how many times an instrument has been used and when it is approaching the end of its life cycle. SPD packing station systems list for \$14,500 each; an administrative station lists at \$13,500.

## Surgical item counting and detection technologies

	Data matrix label	RFID chip	RFID chip	RF tag
<b>Brand name</b>	<b>SurgiCount Safety Sponge System</b>	<b>ORLocate</b>	<b>ClearCount Smart-Sponge System</b>	<b>RF Assure Detection System</b>
<b>Web site</b>	www.surgicountmedical.com	www.orldocate.com	www.clearcount.com	www.rfsurg.com
<b>Distributor</b>	Cardinal Health		Cardinal Health	Medline Industries
<b>FDA cleared</b>	March 2006	August 2010	June 2007	November 2006
<b>What it does</b>	Counts sponges	Counts/detects instruments/sponges	Counts/detects sponges	Detects sponges
<b>What's new</b>	New model scanning device has improved battery life; brighter, higher resolution screen; and faster processor/imager. Regular software upgrades.	Newest system to enter market is first to count, detect instruments.		New detection mat has radiolucent antennas in a gel pad used to scan entire body at end of case with a touch of a button.
<b>System components</b>	<ul style="list-style-type: none"> <li>• Bar-coded sponges and towels</li> <li>• Touch-screen scanning device</li> <li>• Database application that allows for review, management, and analysis of counting reports</li> </ul>	<ul style="list-style-type: none"> <li>• Sponges and instruments with RFID chips</li> <li>• Touch-screen console for tracking and monitoring sponges and instruments</li> <li>• Antennas detect and count sponges and instruments used during the case</li> <li>• Locator wand to scan for instruments or sponges</li> <li>• Asset management module available</li> </ul>	<ul style="list-style-type: none"> <li>• Sponges and towels with RFID chips</li> <li>• Scanner reads and records unique ID for each sponge and verifies initial count</li> <li>• Scanner bucket counts sponges and matches ID number of sponges to initial count</li> <li>• Wand to scan body before case is closed when counts don't match</li> </ul>	<ul style="list-style-type: none"> <li>• RF tagged sponges and towels</li> <li>• RF detection console</li> <li>• RF detection mat used to scan body at end of case</li> <li>• Wand to scan linen and trash bins and around sterile field to locate a missing sponge</li> <li>• Reporting capabilities</li> </ul>
<b>Cost</b>	\$12 per case	\$100,000 per OR, could be reduced to \$70,000, depending on number of ORs	\$10-\$13 per procedure	\$15 per case
<b>No. of installations</b>	>50 hospitals	Pilot expected to start in January 2011	56 hospitals	>100 hospitals

*Note: Cost and installation data provided by companies.*

### Computer-assisted sponge counting

The SurgiCount Safety-Sponge System ([www.surgicountmedical.com](http://www.surgicountmedical.com)) is the only system that uses a 2-dimensional data matrix label to count sponges. A computer-assisted scanner records the unique code embedded in each sponge. The size and flexibility of the data matrix code allow it to be embedded even in tiny neuro patties and tonsil sponges, the company says.

At the end of a case, the system generates a report of the count.

Sponges are scanned and recorded during initial and final counts. Because each sponge has a unique code, the technology will not allow the same sponge to be counted more than once.

The Mayo Clinic in Rochester, Minnesota, has been using the Safety-Sponge System for the past year with no retained sponges identified.

"We concluded that sponges were our biggest problem, and we wanted to add technology to help with the counting," said Robert Cima, MD, MA, vice chairman, department of surgery and associate professor of surgery at the Mayo Clinic. Speaking at the Managing Today's OR Suite Conference in the fall in Orlando, he reported that the technology has reduced total reportable RSIs by nearly 70%.

Notes Dr Gibbs, "We have seen this system being adopted at large single institutions that have a lot of complexity and turnover of residents and nurses."

### **RFID chip technology**

The SmartSponge System ([www.clearcount.com](http://www.clearcount.com)), an RFID-based technology, combines sponge counting and detection. The system reads and records a unique identification (ID) number for each sponge during the initial count and provides a 1-to-1 reconciliation in the final count by matching the ID numbers to sponges. The embedded RFID tags are smaller than a dime.

At the beginning of a case, the nurse passes the sponges over a scanner that counts and reads each sponge's ID. The system's LCD screen shows the rolling count.

When surgery is complete, the used sponges are placed in a "smart" bucket that counts each sponge, even if the sponges are stuck together, and the count is displayed on the screen. Because RFID does not require a line of sight between the reader and RFID chips, there is no need to separate sponges or orient the chips in order to scan them, the company says.

"The smart bucket may prove to be a real work saver and safety device for OR nurses, who one day may not have to touch bloody sponges to count them," Dr Gibbs notes.

When initial and final counts don't match, a wand is used to scan the body before the incision is closed to detect if a sponge is present. A light on the wand turns red, and an alarm sounds when the sponge is found. The sponge must be retrieved and added to the bucket to reconcile the final count.

A small 2006 study of an investigational device using this technology by Alex Macario, MD, and colleagues found a detection accuracy of 100% for the wand device.

### **RF tag technology**

RF Surgical Systems, Inc ([www.rfsurg.com](http://www.rfsurg.com)) has added a new detection mattress system to its sponge detection technology, which uses RF tagged sponges. The company continues to offer a detection wand for locating lost sponges that may be in the trash, linen, or elsewhere in the room.

RF Surgical uses passive low-frequency RF tags, which the company says perform better than RFID chips in fluids and blood, dense tissue, and through bone and metal without interfering with OR equipment. The RF tags have a yes-no signal to indicate whether an item is present but do not have a means to count items.

The new detection mattress contains an array of 6 radiolucent antennas.

The patient lies on the reusable gel mattress, which is covered with a sheet during surgery. At the end of the case, the nurse pushes a button to perform a hands-free scan of the entire body. If an RF-tagged sponge has been left in the patient, an alarm sounds, and a visual display on the console alerts the staff.

"The mattress eliminates human error in the wandering," Victoria M. Steelman, PhD, RN, CNOR, FAAN, told *OR Manager*. Steelman, who is assistant professor in the College of Nursing, University of Iowa Hospital and Clinics, Iowa City, performed a study to find if RF technology could detect sponges through the torso of morbidly obese patients. She found the wand alone had 100% sensitivity if used correctly.

Interim results of a 5-hospital study indicated the RF technology reduced the need for postop x-rays, decreased stress in the OR during closing, and easily identified retained foreign objects. A poster on the study was presented at the American College of Surgeons meeting in Fall 2010 by Christopher Rupp, MD, a surgeon at the University of North Carolina. The study was partly funded by RF Surgical. ♦

—Judith M. Mathias, MA, RN

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## Some retained items beyond reach of technology

Though technology may help prevent some retained items, it wouldn't have prevented 6 of the 8 events recently reported from California. Eight of the state's hospitals were fined \$25,000 to \$75,000 in November 2010 for retained items, including:

- 2 sponges
- a blade for a retractor delivered by a sales rep at the last minute

- part of a Guidant Heartstring proximal seal system
- a guidewire
- a non-radiopaque blue towel used to stanch bleeding in an emergency case
- a malleable retractor
- a drill bit.

Under California law, retained items are one of 28 medical errors hospitals must report because they place patients at risk of death or serious injury. The state can issue fines of \$50,000 for the first event, \$75,000 for the second, and \$100,000 for the third or subsequent errors at the same hospital.

*The reports are posted at [www.cdph.ca.gov/Pages/NR10-87-.aspx](http://www.cdph.ca.gov/Pages/NR10-87-.aspx)*

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## **5 top reasons counts are likely to fail**

An analysis shows the top 5 causes for potential failures involving manual surgical counts are:

- distraction
- multitasking
- not following procedures
- time pressure
- emergency cases.

The findings are from a failure modes and effects analysis (FMEA) on managing sponges, conducted by Victoria Steelman, PhD, RN, CNOR, FAAN. The study has been accepted for publication by the *AORN Journal*.

Education—the number one intervention after a retained item event—won't fix the problem, she says, because none of the failure modes is related to a knowledge deficit.

Other common strategies used after an event, disciplining the employee or reinforcing the policy, work only 14% of the time, she notes.

Counting is not enough to prevent retained sponges 100% of the time, Steelman notes, and ORs need to start evaluating the available technology for assistance.

"I'm not advocating for one technology over the others," she says. "I'm just saying that it's time we start looking at technology to assist us with this. I think all of the technologies are an improvement over counting alone."

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.2

**DATE:** March 10, 2011

**ACTION REQUESTED:** Registered Nurse Advisories

**REQUESTED BY:** Janette Wackerly, MBA, RN, NEC  
Liaison Practice Committee

**BACKGROUND:**

At the Board's January 2, 2011 the Practice Committee was requested to have legal counsel review the following advisories for acceptance:

- Abandonment of Patients
- Nursing Student Workers
- Reproductive Privacy Act
- The RN as First Assistant to the Surgeon

Legal had opportunity to review the Registered Nurse Advisories and provide changes as determined. The above advisories are now available for the practice committee's review, the updated advisories are attached and deleted advisories are attached.

The following are changes and or no changes to the above advisories

Abandonment of Patient...addition of term "generally" added in bold

Nursing Student Worker...no addition or changes.

Reproductive Privacy Act...addition in bold.

The RN as First Assistant to the Surgeon...changes in paragraph bolded.

**NEXT STEPS:** Board

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686



## ABANDONMENT OF PATIENTS

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Inquiries have been received by the Board of Registered Nursing (BRN) regarding which actions by a nurse constitute patient abandonment and thus may lead to discipline against a nurse's license.

**Generally** for patient abandonment to occur, the nurse must:

- a) Have first **accepted** the patient assignment, thus establishing a nurse-patient relationship, and then
- b) **Severed** that nurse-patient relationship without giving reasonable notice to the appropriate person (e.g., supervisor, patient) so that arrangements can be made for continuation of nursing care by others.

A nurse-patient relationship **generally** begins when responsibility for nursing care of a patient is accepted by the nurse. Failure to notify the employing agency that the nurse will not appear to work an assigned shift is not considered patient abandonment by the BRN, nor is refusal to accept an assignment considered patient abandonment. Once the nurse has accepted responsibility for nursing care of a patient, severing of the nurse-patient relationship without reasonable notice may lead to discipline of a nurse's license.

RNs must exercise critical judgment regarding their individual ability to provide safe patient care when declining or accepting requests to work overtime. A fatigued and/or sleep deprived RN may have a diminished ability to provide safe, effective patient care. Refusal to work additional hours or shifts would not be considered patient abandonment by the BRN.

The RN who follows the above BRN advisory statement will not be considered to have abandoned the patient for purposes of Board disciplinary action. However, it should be noted that the BRN has no jurisdiction over employment and contract issues.

## NURSING STUDENT WORKERS

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A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved Work Study Course in a California approved prelicensure nursing program.

### Background:

The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business and Professions Code 2729 (a) ). A work-study course offered by a nursing program complies with this section of law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

### Work-Study Program

The nursing programs in California are responsible for following the Board's guidelines in developing a work-study course as follows:

- 1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied
  - A student must have acquired clinical competence in these skills. A list of skills competencies are provided to the clinical agency (work-study site).
  - No new skills may be taught during this course
  - Hours of instruction for the course follow the formula per CCR 1426(g)(2)
  - A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring the student.
- 2) Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.
- 3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.
- 4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.
- 5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

### Approval of work-study program

- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the curriculum revision guidelines.

**BOARD OF REGISTERED NURSING**

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Louise R. Bailey, M.Ed., RN Executive Officer



## **GUIDELINES FOR WORK STUDY COURSES**

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### Background:

The Nursing Practice Act permits students enrolled in a Board approved prelicensure nursing program to render registered nursing services when these services are incidental to a course of study in the program (Business & Professions Code Section 2729[a]). A work-study course offered by a nursing program complies with this section of the law and provides additional clinical experiences for student nurses admitted to and enrolled in its own nursing program. With a work-study program, nursing students are exposed to the realities of the clinical environment and have the opportunity to master learned skills. Additionally, clinical agencies benefit by the student nurse's skills and have the opportunity to attract new graduate nurses to their facility.

### Guidelines to develop a work-study course are as follows:

- 1) Nursing program develops a course in which previously learned nursing theory and clinical skills are applied.
  - A student must have acquired clinical competence in these skills. A list of skills competencies is provided to the clinical agency (work-study site).
  - No new skills may be taught during this course.
  - Hours of instruction for the course follow the formula per CCR 1426(g)(2).
  - A course faculty of record is available and is responsible for ongoing communication with students and agency and monitoring of student progress.
- 2) Nursing program develops an agreement with a clinical agency with which it has a contract, to provide a work-study course for which a student receives academic credit. Compensation of the student by the practice site is encouraged.
- 3) The clinical agency agrees to the objectives of the course and provides mentors or preceptors for direct supervision of students.
- 4) The instructor and agency mentors meet at regular intervals to discuss student progress and jointly share in the evaluation of the student.
- 5) The course instructor has the final responsibility to evaluate and grade students and their mastery of the course objectives.

### Approval of work-study course:

- All work-study courses require Board approval prior to course implementation.
- Nursing program submits a minor curriculum revision request to the assigned nursing education consultant following the Curriculum Revision Guidelines (EDP-R-09).



## STUDENT WORKERS

A student nurse worker may not perform nursing functions beyond the level of a nursing assistant unless enrolled in a BRN approved student-worker course developed through collaboration of a Board approved nursing program and the health care facility employing the student.

In order to determine which functions such student workers and other nursing assistants may perform, first consider the following definition from the Nursing Practice Act:

The practice of nursing means those functions, including basic health care, which

- (1) help people cope with difficulties in daily living,
- (2) are associated with their actual or potential health or illness problems or the treatment thereof,
- (3) require a substantial amount of scientific knowledge or technical skill.

As a general operating principle, basic health care functions which possess the first two characteristics may be performed by nursing assistants; functions which possess the third characteristic may not be performed by nursing assistants.

A few examples of functions possessing the third characteristic, i.e., require a substantial amount of scientific knowledge or technical skill, are nasogastric and gastrostomy feedings, tracheostomy care, catheterization, regulation of intravenous infusions and administration of drugs.

Although the mechanics of performing such procedures may be taught quite easily, the ability to assess the patient before and throughout the procedure and to respond appropriately to the patient's reactions derives from additional substantial scientific knowledge and technical skill, and for these reasons are excluded from the practice of unlicensed nurses.

The Attorney General, recently asked if certified nursing assistants can lawfully perform nasogastric or gastrostomy feeding, concluded that they may not. This conclusion was based on a review of the steps for performing the procedures and consideration of the potential for complications, such as the introduction of fluid into the patient's lungs with consequent patient harm. Nursing management may use this same process to make a determination regarding the suitability of assigning a function to a non-nurse.

Nursing management should be aware that the BRN

- holds nursing management responsible for making nursing assignments in accord with the Nursing Practice Act;
- investigates all reports/complaints of unlicensed nursing activity; and
- when evidence supports charges that a registered nurse has assigned a nursing assistant to perform registered nursing functions, takes appropriate disciplinary action against the responsible registered nurse.

## REPRODUCTIVE PRIVACY ACT

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**Website:** <http://leginfo.ca.gov/>

**Effective January 1, 2003: Health and Safety Code 123460**

The Reproductive Privacy Act (**Health and Safety Code 123460 et seq**) provides that every individual possesses a fundamental right to privacy with respect to reproductive decisions, including (A) the fundamental right to choose or refuse birth control, and (B) the fundamental right to choose to bear children or obtain an abortion. This new law provides that the state shall not deny or interfere with woman's fundamental right to choose to bear a child or obtain an abortion prior to viability of the fetus, as defined, or when necessary to protect her life and health.

**Business and Professions Code section 2253 permits a person to assist in performing a surgical abortion if he or she has a license that authorizes the performance of such activity.**

The BRN's interpretation is that the registered nurse, certified nurse practitioner, or certified nurse-midwife may perform the nursing functions necessary to assist with a surgical abortion.

**Business and Professions Code section 2253 permits a person to perform or assist in performing the functions necessary for a nonsurgical abortion if he or she has a license that authorizes the performance of such activity.**

The BRN's interpretation is that the registered nurse may perform or assist in performing the functions necessary for a nonsurgical abortion including medication administration and patient teaching.

The nurse practitioner or nurse-midwife may perform or assist in performing functions necessary for nonsurgical abortion by furnishing or ordering medications in accord with his or her approved standardized procedures.

The Reproductive Privacy Act includes the following definitions:

"Abortion" means any medical treatment intended to induce the termination of a pregnancy except for the producing of a live birth.

"Pregnancy" means the human reproductive process, beginning with the implantation of an embryo.

"State" means the State of California, and every county, city, town and municipal corporation, and quasi-municipal corporation in the state.

"Viability" means the point in a pregnancy when, in the good faith medical judgment of a physician, on the particular facts of the case before that physician, there is a reasonable likelihood of the fetus's sustained survival outside the uterus without the application of extraordinary medical measures.

The performance of an abortion is unauthorized if either of the following is true:

- The person performing or assisting in performing the abortion is not a health care provider authorized to perform or assist in performing an abortion pursuant to Section 2253 of the Business and Professions Code.
- The abortion is performed on a viable fetus, and both of the following are established.
  - In the good faith medical judgment of the physician, the fetus was viable.
  - In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

## REPRODUCTIVE PRIVACY ACT

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**Website:** <http://leginfo.ca.gov/>

**Effective January 1, 2003**

Senate Bill 1301 (Kuehl), Chapter 385, was signed by Governor Gray Davis on September 5, 2002. The Reproductive Privacy Act provides that every individual possesses a fundamental right to privacy with respect to reproductive decisions, including (A) the fundamental right to choose or refuse birth control, and (B) the fundamental right to choose to bear children or obtain an abortion. This new law provides that the state shall not deny or interfere with woman's fundamental right to choose to bear a child or obtain an abortion prior to viability of the fetus, as defined, or when necessary to protect her life and health.

The Reproductive Privacy Act deletes the provisions of the Therapeutic Abortion Act including the name of the act.

The Reproductive Privacy Act enacts changes to the Business and Professions Code, Section 2253 to allow registered nurses, certified nurse practitioners, certified nurse-midwives with valid, unrevoked, and unsuspended licenses or certificates to assist in the performance of a surgical abortion and to assist in the performance of non-surgical abortion.

The BRN's interpretation is that the registered nurse, certified nurse practitioner, or certified nurse-midwife may perform the nursing functions necessary to assist with a surgical abortion.

The BRN's interpretation is that the registered nurse may perform or assist in performing the functions necessary for a nonsurgical abortion including medication administration and patient teaching.

The nurse practitioner or nurse-midwife may perform or assist in performing functions necessary for nonsurgical abortion by furnishing or ordering medications in accord with his or her approved standardized procedures.

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  - In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

## THE RN AS FIRST ASSISTANT TO THE SURGEON

Association of periOperative Registered Nurses, AORN Standards and Recommended Practices: [www.aorn.org](http://www.aorn.org)

AORN-RN First Assistant: <http://www.aorn.org/CareerCenter/CareerDevelopment/RNFirstAssistant/>

AORN Standards for RN First Assistant Education Program are available AORN Perioperative Standards and Recommended Practices. See above website

The role of RN first assistant to the surgeon requires the performance of a combination of nursing and medical functions. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks. The RN first assistant may provide other advanced assistance, such as mobilization of tissue, patient positioning and directing other surgical team members with specific individual tasks. The RN first assistant, practices perioperative nursing and must have acquired the necessary specific knowledge, skills and judgment. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. In order to perform those functions considered to be first assistant to the surgeon, the RN must adhere to standardized procedures.

### STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrator in either a licensed health facility or an organized health care system which is a licensed health **facility where the standardized procedures are to be used. A licensed health facility is defined as a facility licensed under Chapter 2 (commencing with section 1250) of Division 2 of the Health and Safety Code. An organized health care system which is not licensed health facility under Chapter 2 of Division 2 of the Health and Safety Code includes clinics, home health agencies, physicians' offices, and public or community health services.** Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse.

### GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES

Standardized procedures are not subject to prior approval by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR Section 1379.)

- (a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision there of.
- (b) Each standardized procedure shall:
  - 1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.
  - 2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.
  - 3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.

- 4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.
- 5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.
- 6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.
- 7) Specify the scope of supervision required for performance of standardized procedure functions, for example, telephone contact with the physician.
- 8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient's physician** concerning the patient's condition.
- 9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.
- 10) Specify patient **record-keeping** requirements.
- 11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.



## THE RN AS FIRST ASSISTANT TO THE SURGEON

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The role of RN first assistant to the surgeon requires the performance of a combination of nursing and medical functions. The RN first assistant directly assists the surgeon by controlling bleeding, providing wound exposure, suturing and other surgical tasks. The RN first assistant may provide other advanced assistance, such as mobilization of tissue, patient positioning and directing other surgical team members with specific individual tasks. The RN first assistant practices perioperative nursing and must have acquired the necessary specific knowledge, skills and judgment. The RN first assistant practices under the supervision of the surgeon during the intraoperative phase of the perioperative experience. In order to perform those functions considered to be first assistant to the surgeon, the RN must adhere to standardized procedures. The RN first assistant does not concurrently function as a scrub nurse.

The RN first assistant is not the same as an individual designated to perform scrub functions. A “scrub technician” is any individual not licensed to practice professional nursing who passes the surgeon the surgical instruments, sponges, and other items needed during the surgical procedure. The Board has interpreted that a non-licensed individual may perform scrub functions only as an assigned technical function under the direct supervision of a perioperative registered nurse.

Criteria for education of the registered nurse in the role of surgical first assistant would include theory and clinical to provide demonstrated competency in:

- Ø Performing individualized surgical care management before, during and after surgery.
- Ø Surgical anatomy and physiology and surgical technique related to first assisting.
- Ø Carrying out intraoperative behaviors including handling tissue, providing exposure, using surgical instruments, suturing and controlling blood loss.
- Ø Application of principles of asepsis and infection control.
- Ø Recognizing surgical hazards and initiation of appropriate corrective and preventative actions.

It is recommended that RNs qualifying as first assistants have documented proficiency in perioperative nursing practice in both a scrub and circulation roles. It is important to be aware that although the RN may perform the first assistant’s surgical duties, the RN does not possess the same medical surgical knowledge, skill, and judgment that a surgeon does and provisions should be made to protect the consumers’ health in the event the surgeon could not continue for any reason.

### ESTABLISHMENT OF CLINICAL PRIVILEGES FOR THE RN FIRST ASSISTANT

The process of granting clinical privileges should include the following mechanisms:

- Ø assessing individuals qualifications for practice
- Ø assessing initial and yearly proficiency performance
- Ø assessing compliance with institutional and departmental policies
- Ø defining lines of accountability
- Ø quality improvement methods including peer review

### STANDARDIZED PROCEDURES FOR MEDICAL FUNCTIONS

The means designated to authorize performance of a medical function by a registered nurse is a standardized procedure developed through collaboration among registered nurses, physicians and administrators in the **organized health care system** in which it is to be used. Because of this interdisciplinary collaboration, there is accountability on several levels for the activities to be performed by the registered nurse. Section 2725 defines “organized health care systems” include, but are not limited to, licensed health facilities, clinics, home health agencies, physician’ offices, and public or community health services.

## **GUIDELINES FOR DEVELOPING STANDARDIZED PROCEDURES**

Standardized procedures are not subject to prior approval by the boards that regulate nursing and medicine; however, they must be developed according to the following guidelines which were jointly promulgated by the Board of Registered Nursing and the Medical Board of California. (Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR Section 1379.)

- (a) Standardized procedures shall include a written description of the method used in developing and approving them and any revision there of.
- (b) Each standardized procedure shall:
  - 1) **Be in writing, dated and signed by the organized health care system** personnel authorized to approve it.
  - 2) Specify **which standardized procedure functions** registered nurses may perform and under what circumstances.
  - 3) State any specific **requirements which are to be followed** by registered nurses in performing particular standardized procedure functions.
  - 4) Specify any **experience, training and/or education** requirements for performance of standardized procedure functions.
  - 5) Establish a method for initial and continuing **evaluation** of the competence of those registered nurses authorized to perform standardized procedure functions.
  - 6) Provide for a method of maintaining a written record of those **persons authorized to perform** standardized procedure functions.
  - 7) Specify the scope of supervision required for performance of standardized procedure functions, for example, telephone contact with the physician.
  - 8) Set forth any specialized circumstances under which the registered nurse is to immediately **communicate with a patient’s physician** concerning the patient’s condition.
  - 9) State the limitations on **settings**, if any, in which standardized procedure functions may be performed.
  - 10) Specify patient **record-keeping** requirements.
  - 11) Provide for a method of **periodic review** of the standardized procedures.

An additional safeguard for the consumer is provided by steps four and five of the guidelines which, together, form a **requirement that the nurse be currently capable** to perform the procedure. The registered nurse who undertakes a procedure without the competence to do so is grossly negligent and subject to discipline by the Board of Registered Nursing.

## **STANDARDIZED PROCEDURE EXAMPLES**

The attached examples are not required formats. The Board of Registered Nursing does not recommend or endorse the medical/surgical management of these example protocols.

### **RNFA STANDARDIZED PROCEDURE**

#### **I. Standard**

The RN First Assistant renders direct patient care as part of the perioperative role by assisting the surgeon in the surgical treatment of the patient. The responsibility of functioning as first assistant must be based on documented knowledge and skills acquired after specialized preparation and formal instruction.

## II. Policy

- A. The safety and welfare of the patient should be given primary consideration in the selection of a first assistant in surgery. In the absence of a qualified physician, the registered nurse who possesses appropriate knowledge and technical skills is the best qualified non-physician to serve as the first assistant.
- B. The RNFA practices under the direct supervision of the surgeon during the surgical intervention.
- C. The RNFA must perform only as first assistant and not concurrently as scrub nurse.
- D. Only in extreme emergencies should an RNFA be expected to assist on procedures that present an unusual hazard to life.
- E. The RNFA must adhere to the policies of the institution and must remain within the scope of practice as stated by the Nursing Practice Act of the State of California.
- F. The RNFA may perform technical functions:
  - 1. Assist with the positioning, prepping and draping of the patient or perform these independently, if so directed by the surgeon.
  - 2. Provide retraction by:
    - a. Closely observing the operative field at all times.
    - b. Demonstrating stamina for sustained retraction.
    - c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
    - d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
    - e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.
  - 3. Provide hemostasis by:
    - a. Applying electrocautery tip to clamps or vessels in a safe and knowledgeable manner as directed by the surgeon.
    - b. Sponging and utilizing pressure as necessary.
    - c. Utilizing suctioning techniques.
    - d. Applying clamps on superficial vessels and the tying off, electrocoagulation of them as directed by the surgeon.
    - e. Placing suture ligatures in the muscle, subcutaneous, and skin layers.
    - f. Placing hemoclips on bleeders as directed by the surgeon.
  - 4. Perform knot tying by:
    - a. Having knowledge of the basic techniques.
    - b. Tying knots firmly to avoid slipping.
    - c. Avoiding undue friction to prevent fraying of suture.
    - d. Carrying knot down to the tissue with the tip of the index finger and laying the strands flat.
    - e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
  - 5. Provide closure of layers by:
    - a. Correctly approximating the layers under the direction of the surgeon.
    - b. Demonstrating a knowledge of different types of closure.
    - c. Correctly approximating skin edges when utilizing skin staples.
  - 6. Assist the surgeon at the completion of the procedure by:
    - a. Affixing and stabilizing all drains.
    - b. Cleaning the wound and applying the dressing.
    - c. Assist with applying casts or plaster splints.

NOTE: The above specifications are general guidelines and do not reflect all duties in all specialty areas. Therefore, they should not preclude the performance of other duties which, in the judgment of the surgeon, can be successfully accomplished by the RN First Assistant. However, the RN First Assistant must know his/her limitations and may refuse to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

### STANDARDIZED PROCEDURE

<b>Procedure:</b>	Intraoperative Retracting
<b>Personnel:</b>	Registered Nurse First Assistants
<b>Purpose:</b>	To direct the RNFA in providing retraction of the surgical field
<b>Desired Outcome:</b>	Adequate surgical exposure without subsequent tissue/organ compromise.
<b>Supportive Data:</b>	Selection and placement of an appropriate retraction instrument will assist the surgeon by providing exposure and optimum visualization of the surgical site.
<b>Process:</b>	<p>The RNFA will assist the surgeon by providing intraoperative retraction using the following measures:</p> <ol style="list-style-type: none"><li>1. Retracting tissues or organs by the use of the hand.</li><li>2. Placing and holding surgical retractors.</li><li>3. Packing sponges or laparotomy pads into body cavities to hold tissues and organs out of the operative field.</li><li>4. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.</li></ol>

### STANDARDIZED PROCEDURE

<b>Procedure:</b>	Intraoperative Wound Closure
<b>Personnel:</b>	Registered Nurse First Assistants
<b>Purpose:</b>	To direct the RNFA in providing proper suturing of tissue during a surgical procedure.
<b>Desired Outcome:</b>	Tissue will heal as expected without complications from the suturing process.
<b>Supportive Data:</b>	Proper suturing is vital to insure hemostasis, wound alignment, and tissue healing.
<b>Process:</b>	<p>The RNFA will suture tissue, using instruments and suture material as directed by the surgeon, by:</p> <ol style="list-style-type: none"><li>1. Correctly approximating tissue layers.</li><li>2. Approximating tissue appropriately to avoid excess tension and tissue necrosis.</li><li>3. Tying knots firmly to avoid slipping.</li><li>4. Using staples, clips, or other devices to approximate tissue.</li></ol>

### STANDARDIZED PROCEDURE

<b>Procedure:</b>	Intraoperative Hemostasis
<b>Personnel:</b>	Registered Nurse First Assistants
<b>Purpose:</b>	To direct the RNFA in providing Hemostasis of the surgical field.
<b>Desired Outcome:</b>	Minimal blood loss during surgery.

**Supportive Data:** Providing a dry operative field promotes adequate visual assessment and access to the surgical site. Effective hemostasis is essential to carry out surgery in a time-efficient manner and to prevent excessive blood loss.

**Process:** The RNFA will assist the surgeon by providing intraoperative hemostasis using the following measures:

1. Aspiration of blood and other fluids from the operative site, as directed by the surgeon.
2. Sponging the wound or other area of dissection, as directed by the surgeon.
3. Using hemostasis or other surgical instruments to clamp bleeding tissue, as directed by the surgeon.
4. Using sutures to tie off clamped blood vessels or other tissue, as directed by the surgeon.
5. Using electrocautery or other surgical device to cauterize tissue, or surgical instruments clamped to tissue.
6. Place hemoclip, or other ligating devices on vessels or tissue, as directed by the surgeon.

### **STANDARDIZED PROCEDURE**

**Procedure:** Intraoperative Tissue Manipulation

**Personnel:** Registered Nurse First Assistants

**Purpose:** To direct the RNFA in the manipulation of tissue and use of surgical instruments during a surgical procedure.

**Desired Outcome:** No tissue damage due to improper handling, or use of surgical instruments.

**Supportive Data:** Proper handling of tissue and selection and use of surgical instruments is essential to proper treatment of tissue and rapid healing of the surgical site.

**Process:** The RNFA will use surgical instruments and suture material to manipulate tissue, as directed by the surgeon, to:

1. Expose and retract tissue.
2. Clamp and sever tissue.
3. Grasp and fixate tissue with screws, staples, and other devices.
4. Drill, ream, and modify tissue.
5. Cauterize and approximate tissue.

### **PROCEDURE FOR THE RNFA IN THE EVENT THE SURGEON BECOMES INCAPACITATED OR NEEDS TO LEAVE FOR AN EMERGENCY DURING SURGERY**

1. In the event the operating surgeon, during surgery, becomes incapacitated or needs to leave the OR due to an emergency, the responsibility of the RNFA is to:
  - a. Maintain hemostasis, according to the approved standardized procedure.
  - b. Keep the surgical site moistened, as necessary, according to the type of surgery.
  - c. Maintain the integrity of the sterile field.
  - d. Remain scrubbed in appropriate attire (gown, mask, gloves, cap).
  - e. Remain at the field while a replacement surgeon is being located.
2. The RN circulator will initiate the procedure for obtaining a surgeon in an emergency.

<b>MEDICAL CENTER: NURSING Operating Room</b>	<b>POLICY/PROCEDURE TITLE:</b> Standard Procedure for Registered Nurse First Assistant		
<b>DISTRIBUTE TO:</b>	<input type="checkbox"/> ADMINISTRATIVE	<input type="checkbox"/> CLINICAL	PAGE 1 OF 2
<b>RELATED TO:</b> <input type="checkbox"/> Hospital Instruction (HU) <input checked="" type="checkbox"/> Nursing Practice Std.	Effective Date:                      Revision Date:		
<input type="checkbox"/> JCAHO NC.1 - 1.2.1 <input type="checkbox"/> Patient Care Std.	Unit/Department of Origin:		
<input type="checkbox"/> QA <input type="checkbox"/> Other	Approved by: Interdisciplinary Practice Committee		
<input checked="" type="checkbox"/> Title 22	File Name: ORNURSE.p&p		

**I. PURPOSE:**

This standardized procedure will provide guidelines for the registered nurse assisting the surgeon in the first assistant role.

**II. POLICY STATEMENT:**

The RNFA may function in the expanded role, provided in this standardized procedure, which is approved by the Interdisciplinary Practice Committee. This role requires the direct supervision of the sponsoring primary surgeon.

**III. GENERAL GUIDELINES:**

A. The RNFA will assist the surgeon by providing intraoperative retraction giving exposure and optimum visualization of the surgical site as directed by the surgeon.

1. Retracting tissue or organs by the use of the hand, closely observing the operative field at all times.
2. Placing or holding surgical retractors in the position set by the surgeon with regard to surrounding tissue.
3. Packing sponges into body cavities to hold tissue or organs out of the operative field.
4. Managing all instruments in the operative field to prevent obstruction of the surgeons views.

B. The RNFA will assist the surgeon by providing intraoperative hemostasis promoting adequate visual assessment and access to the surgical site as directed by the surgeon.

1. Aspiration of blood and other fluids from the operative site using suctioning techniques.
2. Sponging the wound and utilizing pressure as directed.
3. Placing hemostats on other instruments to clamp tissue or bleeding vessels.
4. Applying electrocautery tip to clamps or vessels as directed.
5. Placing suture ligatures on vessels or tissue as directed.
6. Perform knot tying firmly to avoid slipping.

- C. The RNFA will use surgical instruments to perform dissection or manipulate tissue as directed by the surgeon.
  - 1. Dissects only those layers required to provide exposure to the operative area as directed.
  - 2. Dissect only the superficial tissue of lower extremity veins during cardiac or vascular surgery as directed.
  - 3. Grasps and fixates tissue with staples or screws.
  - 4. Drills and modifies bone tissue as directed.
- D. The RNFA will suture tissue and insure hemostasis or wound alignment as directed by surgeon.
  - 1. Approximating tissue layers as directed to avoid excess tension or tissue necrosis.
  - 2. Uses suture, staples, skin clips or other devices to correctly approximate tissue.

IV. REQUIREMENTS FOR RN PRIVILEGED IN THEIR EXPANDED ROLE:

- A. Will meet all requirements of the hospital Non-physician/Non-Employee Policy.
- B. Certified in basic Cardiopulmonary life support.
- C. Nationally certified operating room nurse through the Association of Operating Room Nurses (AORN).
- D. Minimum of three (3) years of operating room experience in both the scrub and circulating roles.
- E. Proof of successful completion of a structured RNFA course and completion of 20 hours or 10 cases of proctoring by the sponsoring surgeon.
- F. Will receive approval from the surgical sub-specialty of the sponsoring physician.
- G. Will be evaluated by the hospital staff for compliance to OR policies and by the sponsoring surgeon annually.

V. DEVELOPMENT AND APPROVAL OF STANDARDIZED PROCEDURE:

- A. This policy will be developed and approved by authorized representatives of administration, medicine, and nursing.
- B. This standardized procedure will be reviewed and approved every three years.

- 1. Administration \_\_\_\_\_ Date \_\_\_\_\_
- 2. Medicine \_\_\_\_\_ Date \_\_\_\_\_
- 3. Nursing \_\_\_\_\_ Date \_\_\_\_\_

VI. RN'S AUTHORIZED TO PERFORM STANDARDIZED PROCEDURE:

- 1. \_\_\_\_\_ Date \_\_\_\_\_
- 2. \_\_\_\_\_ Date \_\_\_\_\_
- 3. \_\_\_\_\_ Date \_\_\_\_\_

**BOARD OF REGISTERED NURSING**  
**Nursing Practice Committee**  
**Agenda Item Summary**

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**AGENDA ITEM:** 10.3

**DATE:** March 10, 2011

**ACTION REQUESTED:** Nurse Practitioner Advisories

**REQUESTED BY:** Janette Wackerly, MBA, RN, NEC  
Liaison Practice Committee

**BACKGROUND:**

Legal had opportunity to review the Nurse Practitioner Advisories and provide changes as determined. The above advisories are now available for the practice committee's review, the updated advisories are attached and deleted advisories are attached.

The advisories relate to Nurse Practitioner Practice:

- Clinic's Eligible for Licensure
- General Information: Nurse Practitioner Practice
- Nurse Practitioner in Long-Term Care

Advisory titled General Information: Nurse Practitioner Practice is based on the Nursing Practice Act and California laws enacted pertinent to nurse practitioner practice. The updating includes incorporation of previous advisories marked as deleted.

Nurse Practitioner in Long Term Care Settings extracted from Welfare and Institutions Code and is on page 303 -304 in 2011 Edition California Nurse Practice Act with Regulations and Related Statutes. The updating deleted previous advisory NP in Long Term Care Setting.

Clinic's Eligible for Licensure extracted from Health and Safety Code and is on page 241-243 in the 2011 Edition of the California Nurse Practice Act with Regulations and Related Statutes. The above on clinics is added to NP advisories and it was not previously listed in the NP advisories.

The Practice Committee may direct staff to forward NP advisories to the Board for approval at their next meeting and if approved by the Board post the NP advisories on the BRN Website.

**NEXT STEPS:** Board

**FISCAL IMPLICATIONS, IF ANY:** None

**PERSON(S) TO CONTACT:** Janette Wackerly, MBA, RN  
Nursing Education Consultant  
(916) 574-7686



## CLINIC'S ELIGIBLE FOR LICENSURE

Website: <http://leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc&codebody=1204&hits=20>

### Extracted from Health and Safety Code

#### Division 2

#### Licensing Provisions

#### Chapter 1

#### Clinics

#### Article 1

#### Definitions and General Provisions

### 1204. Clinics eligible for licensure

Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

(b) The following types of specialty clinics shall be eligible for licensure as specialty clinics pursuant to this chapter:

(1) A "surgical clinic" means a clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours. A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.

(2) A "chronic dialysis clinic" means a clinic that provides less than 24-hour care for the treatment of patients with end-stage renal disease, including renal dialysis services.

(3) A "rehabilitation clinic" means a clinic that, in addition to providing medical services directly, also provides physical rehabilitation services for patients who remain less than 24 hours. Rehabilitation clinics shall provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services. A rehabilitation clinic does not include the offices of a private physician in individual or group practice.

(4) An "alternative birth center" means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.

### **1204.3. Alternative birth centers**

(a) An alternative birth center that is licensed as an alternative birth center specialty clinic pursuant to paragraph (4) of subdivision (b) of Section 1204 shall, as a condition of licensure, and a primary care clinic licensed pursuant to subdivision (a) of Section 1204 that provides services as an alternative birth center shall, meet all of the following requirements:

(1) Be a provider of comprehensive perinatal services as defined in Section 14134.5 of the Welfare and Institutions Code.

(2) Maintain a quality assurance program.

(3) Meet the standards for certification established by the National Association of Childbearing Centers, or at least equivalent standards as determined by the state department.

(4) In addition to standards of the National Association of Childbearing Centers regarding proximity to hospitals and presence of attendants at births, meet both of the following conditions:

(A) Be located in proximity, in time and distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time of diagnosis of the emergency.

(B) Require the presence of at least two attendants at all times during birth, one of whom shall be either a physician and surgeon or a certified nurse-midwife.

(5) Have a written policy relating to the dissemination of the following information to patients:

(A) A summary of current state laws requiring child passenger restraint systems to be used when transporting children in motor vehicles.

(B) A listing of child passenger restraint system programs located within the county, as required by Section 27360 of the Vehicle Code or Section 27362 of that code.

(C) Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system.

(b) The state department shall issue a permit to a primary care clinic licensed pursuant to subdivision (a) of Section 1204 certifying that the primary care clinic has met the requirements of this section and may provide services as an alternative birth center. Nothing in this section shall be construed to require that a licensed primary care clinic obtain an additional license in order to provide services as an alternative birth center.

(c) (1) Notwithstanding subdivision (a) of Section 1206, no place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, shall be represented or otherwise held out to be an alternative birth center licensed by the state unless it meets the requirements of this section.

(2) Nothing in this subdivision shall be construed to prohibit licensed health care practitioners from providing birth related services, within the scope of their license, in a place or establishment described in paragraph (1).



## GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

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### Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in, Title 16 California Code of Regulations, (CCR), 1484 Standards of Education.

### Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease, Title 16 CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

### Clinically Competent

Clinically competent means that one possess and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice, (Title 16 CCR 1480 c)

### Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions, (Title 16 CCR Section 1485). Business and Professions Code (BPC) Section 2725 provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

### Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters "R.N., N.P." after his/her name alone or in combination with other letters or words identifying categories of specialization,

including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (Title 16 CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (BPC 2835.5)

### **Furnishing Drugs and Devices**

BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2836.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

BPC 2836.1 was amended changing furnishing to include "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

### **Furnishing Controlled Substances:**

The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 the NP who is registered with the United States Drug Enforcement Administration, the furnishing authority or "order" can include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act. There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The proof of a Schedule II course received by the BRN will be noticed on the board's website, [www.rn.ca.gov](http://www.rn.ca.gov), in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f). The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

### **Dispensing Medication**

Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic. Business and Professions Code Section 2725.1 grants to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics.

Effective January 1, 2003, B&P Code Section 2836.1 was amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

### **Authorized Standardized procedures**

Added in legislative session 2003 ch 308 § 34 (SB 819), effective January 1, 2010

**2835.7.** (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in statute or regulation for inclusion in standardized procedures developed through collaboration among administrators and health professionals, including physicians and surgeons and nurses, pursuant to Section 2725, standardized procedures may be implemented that authorize a nurse practitioner to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in the standardized procedures. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(b) Nothing in this section shall be construed to affect the validity of any standardized procedures in effect prior to the enactment of this section or those adopted subsequent to enactment.

### **Sign for the Request and Receipt of Pharmaceutical Samples and Devices.**

Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (B&P Code Section 4061 of the Pharmacy)

### **Treating STDs**

Section 120582 of the Health and Safety Code:

- (a) Notwithstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.
- (b) Notwithstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch ) (AB 648 Ortiz stats 2001 ch 835)

### **Workers' Compensation Reports**

Labor Code section 3209.10 gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability.

### **Veterans with Disabilities Parking Placards:**

Vehicle Code section 5007, 9105, 22511.55 includes nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard.

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

### **Medical Examination School Bus Drivers**

Vehicle Code Section 12517.2 (a) relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the

application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12<sup>th</sup> month thereafter, shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

#### **Informing patient: Positive and Negative aspects of Blood Transfusions**

Section 1645 of the Health and Safety Code authorizes the nurse practitioner and the nurse-midwife who is authorized to give blood to provide the patient with information by means of a standardized written summary as developed or revised by the State Department of Public Health about the positive and negative aspects of receiving autologous blood and direct and nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

#### **Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty**

Section 14132. 41 of the Welfare and Institutions Code provide that services rendered by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, "certified" means nationally board certified in a recognized specialty.

#### **Supervision**

Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

## **Supervision of Medical Assistants**

Medical Board of California link for medical assistant

[http://www.mbc.ca.gov/allied/medical assistant. training.html](http://www.mbc.ca.gov/allied/medical%20assistant%20training.html).

Business and Professions Code 2069 (a) (1) and Health and Safety Code 1240 link is

<http://www.leginfo.ca.gov>

Business & Profession Code Section 2069(a)(1) and Health & Safety Code 1204 provides that a supervising physician and surgeon at a community clinic or free clinic as licensed pursuant to Health and Safety Code 1204 may, at his or her discretion, in consultation with the nurse practitioner, nurse-midwife, or physician assistant provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. The written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, nurse-midwife, or physician assistant and that tasks may be performed when the supervising physician and surgeon are not on site. This delegation to the nurse practitioner or nurse midwife is limited to those licensed clinics under Health and Safety 1240.

## **Citation and Fine**

NPs, like all registered nurses, are subject to citation and fine for violation of the Nursing Practice Act (NPA). Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title "nurse practitioner" without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

## **References**

B&P Code, Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

## **BRN Offices**

Sacramento Office: (916) 322-3350

*For more information, please visit the BRN's Web site at [www.rn.ca.gov](http://www.rn.ca.gov)*



## GENERAL INFORMATION: NURSE PRACTITIONER PRACTICE

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### Scope of Practice

The nurse practitioner (NP) is a registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of health-illness needs in primary health care, who has been prepared in a program that conforms to Board standards as specified in California Code of Regulations, CCR, 1484 Standards of Education.

### Primary Health Care

Primary health care is defined as, that which occurs when a consumer makes contact with a health care provider, who assumes responsibility and accountability for the continuity of health care regardless of the presence or absence of disease CCR 1480 (b). This means that, in some cases, the NP will be the only health professional to see the patient and, in the process, will employ a combination of nursing and medical functions approved by standardized procedures.

### Clinically Competent

Clinically competent means that one possesses and exercises the degree of learning, skill, care ordinarily possessed and exercised by a member of the appropriate discipline in clinical practice (CCR 1480 c)

### Legal Authority for Practice

The NP does not have an additional scope of practice beyond the usual RN scope and must rely on standardized procedures for authorization to perform overlapping medical functions (CCR Section 1485). Section 2725 of the Nursing Practice Act (NPA) provides authority for nursing functions that are also essential to providing primary health care which do not require standardized procedures. Examples include physical and mental assessment, disease prevention and restorative measures, performance of skin tests and immunization techniques, and withdrawal of blood, as well as authority to initiate emergency procedures.

Nurse practitioners frequently ask if they really need standardized procedures. The answer is that they do when performing overlapping medical functions. Standardized procedures are the legal authority to exceed the usual scope of RN practice. Without standardized procedures the NP is legally very vulnerable, regardless of having been certified as a RN, who has acquired additional skills as a certified nurse practitioner.

### Certification

Registered nurses who have been certified as NPs by the California Board of Registered Nursing may use the title nurse practitioner and place the letters "R.N., N.P." after his/her name alone or in combination with other letters or words identifying categories of specialization,

including but not limited to the following: adult nurse practitioner, pediatric nurse practitioner, obstetrical-gynecological nurse practitioner, and family nurse practitioner. (CCR 1481)

On and after January 1, 2008, an applicant will be required for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. (Business and Professions Code 2835.5)

### **Furnishing Drugs and Devices**

BPC Code Section 2836.1 authorizes NPs to obtain and utilize a "furnishing number" to furnish drugs and devices. Furnishing or ordering drugs and devices by the nurse practitioner is defined to mean the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure. Furnishing is carried out according to a standardized procedure and a formulary may be incorporated. All nurse practitioners who are authorized pursuant to Section 2831.1 to furnish or issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

BPC 2836.1 was amended changing furnishing to mean "order" for a controlled substance, and can be considered the same as an "order" initiated by the physician. This law requires the NP who has a furnishing number to obtain a DEA number to "order" controlled substances, Schedule II, III, IV, V. (AB 1545 Correa) stats 1999 ch 914 and (SB 816 Escutia) stats 1999 ch 749.

### **Furnishing Controlled Substances:**

The furnishing or ordering of drugs and devices occurs under physician and surgeon supervision. B&P Code Section 2836.1 extends the NP, who is registered with the United States Drug Enforcement Administration, the furnishing authority or "ordering" to include Schedule II through V Controlled Substances under the Uniform Controlled Substance Act (AB 1196 Montanez) Stats 2004 ch 205 § (AB 2560) There are specified educational requirements that must be met by the furnishing NP who wishes to "order" Schedule II Controlled Substances.

Drugs and/or devices furnished or "ordered" by a NP may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 commencing with Section 11000) of the Health and Safety Code and shall be further limited to those drugs agreed upon by the NP and physician and specified in the standardized procedure.

When Schedule II or III controlled substances, as defined in Section 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a NP, the controlled substance shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. The provision for furnishing Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is to be furnished. A copy of the section for the NP's standardized procedure relating to controlled substances shall be provided upon request to any licensed pharmacist who dispenses drugs or devices when there is uncertainty about the furnishing transmittal order.

The nurse practitioner with an active furnishing number, who is authorized by standardized procedure or protocols to furnish must submit to the BRN an approved course that includes Schedule II Controlled Substances content as a part of the NP educational program or a continuing educational course with required content on Schedule II Controlled substance. The proof of a Schedule II course received by the BRN will be noticed on the board's website, [www.rn.ca.gov](http://www.rn.ca.gov), in the NPF verification section.

A prescription pad may be used as transmittal order forms as long as they contain the furnisher's name and furnishing number. Pharmacy law requires the nurse practitioner name on the drug and/or device container label. The name of the supervising physician is no longer required on the drug/device container label as pharmacy law was amended BPC 1470 (f) (AB 2660 Leno) stats 2004 ch 191. The nurse practitioner DEA number is required for controlled substances. Therefore, inclusion of this information on the transmittal order form will facilitate dispensing of the drug and/or device by the pharmacist.

### **Dispensing Medication**

Business and Professions Code Section 2725.1 allows registered nurses to dispense (hand to a patient) medication except controlled substances upon the valid order of a physician in primary, community, and free clinic.

Business and Professions Code Section 2725.1 was amended to extend to the furnishing nurse practitioner authority to dispense drugs, including controlled substances, pursuant to standardized procedures or protocols in primary, community, and free clinics. (AB 1545 Correa) stats 1999 ch 914)

Effective January 1, 2003, B&P Code Section 2836.1 Furnishing is amended to allow NPs to use their furnishing authority in solo practice per Senate Bill 933 (Figueroa) Chapter 764 signed by Governor Gray Davis on September 20, 2002.

### **Sign for the Request and Receipt of Pharmaceutical Samples and Devices.**

Certified furnishing nurse practitioners are authorized to sign for the request and receipt of complimentary samples of dangerous drugs and devices identified in their standardized procedures or protocols that have been approved by the physician. (SB 1558 Figueroa stats 2002 ch 263) to take effect immediately. This new law amends B&P Code Section 4061 of the Pharmacy law to allow CNMs, NPs, and PAs to request and sign for complimentary samples of medication and devices.

### **Treating STDs**

Amended into Section 120582 of the Health and Safety Code effective January 1, 2007:

- (a) Notwithstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide a prescription antibiotic drugs to the patients sexual partner or partners without examination of that patient's partners.
- (b) Notwithstanding any other provision a nurse practitioner practicing pursuant to BPC Section 2836.1; a certified nurse-midwife practicing pursuant to BPC Section 2746.51; and a physician assistant pursuant to BPC 3502.1 may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted Chlamydia, gonorrhea, or other sexually transmitted

infection, as determined by the Department of Health Services without examination of the patient's sexual partners. (AB 2280 Leno stats 2006 ch ) (AB 648 Ortiz stats 2001 ch 835)

### **Workers' Compensation Reports**

Section 3209.10 added to the labor code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or illness for a worker's compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedure or protocols. The treating physician is required to sign the report and to make a determination of any temporary disability. (AB 2919 Ridley-Thomas stats 2005 extends the operation of this provision indefinitely-AB 1194 Correa stats 2001 ch 229 effective 2001)

### **Veterans with Disabilities Parking Placards:**

Section 5007, 9105, 22511.55 of the Vehicle Code is amended to include nurse practitioners, nurse midwives and physician assistants as authorized health care professionals that can sign the certificate substantiating the applicant's disability for the placard. (AB 2120 Lui stats 2007 ch 116)

Existing law authorizes the Department of Motor Vehicles to issue placards to persons with disabilities and veteran with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities request of the department.

### **Medical Examination School Bus Drivers**

Vehicle Code Section 12517.2 (a) is amended relating to schoolbus drivers driver medical examination to Applicants for an original or renewal certificate to drive a schoolbus, school pupil activity bus, youthbus, general public paratransit vehicle, or farm labor vehicle shall submit a report of medical examination of the applicant given not more than two years prior to the date of the application by a physician licensed to practice medicine , a licensed advanced practice nurse qualified to perform a medical examination, or a licensed physician assistant. The report shall be on a form approved by the department, the Federal Highway Administration, or the Federal Aviation Administration.

Schoolbus drivers, within the same month or reaching 65 years of age and each 12<sup>th</sup> month thereafter, shall undergo a medical examination, pursuant to Section 12804.9, shall submit a report of the medical examination on a form specified in subsection (a) (AB 139 Bass stats 2007, ch 158)

### **Informing patient: Positive and Negative aspects of Blood Transfusions**

Section 1645 of the Health and Safety Code is amended to authorize the nurse practitioner and the nurse-midwife who is authorized to give blood may now provide the patient with information by means of a standardized written summary as developed or revised by the State Department of Public Health about the positive and negative aspects of receiving

autologous blood and direct and nondirected homologous blood to volunteers. (SB 102 Migden stat 2007 ch 88)

Existing law requires, whenever there is reasonable possibility, as determined by a physician, that a blood transfusion may be necessary as a result of medical procedures, that the physician, by means of a standardized written summary that is published by the Medical Board and now by the Department of Public Health and distributed upon request, inform the patient of the positive and negative aspects of receiving autologous blood and directed and non directed homologous blood from volunteers.

### **Medi-Cal Billing: Nurse Practitioner Nationally Certified in a Specialty**

Section 14132. 41 of the Welfare and Institutions Code is amended services provided by a certified nurse practitioner shall be covered under this chapter to the extent authorized by federal law, and subject to utilization controls. The department shall permit a (nationally) certified nurse practitioner to bill Medi-Cal independently for his or her services. If a certified (nationally) nurse practitioner chooses to bill Medi-Cal independently for his or her service, the department shall make payment directly to the certified (nationally) nurse practitioner. For the purposes of this section, "certified" means nationally board certified in a recognized specialty.

### **Supervision**

Supervision of the NP performing an overlapping medical function is addressed in the standardized procedure and may vary from one procedure to another depending upon the judgment of those developing the standardized procedure. As an example, in one women's clinic the supervision requirement for performing a cervical biopsy was that a physician must be physically present in the facility, immediately available in case of emergency. For all other standardized procedure functions, the supervision requirement was for a clinic physician to be available by phone.

The furnishing or ordering of drugs and devices by nurse practitioners occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time the patient is being examined by the nurse practitioner. For furnishing purposes, the physician may supervise a maximum of no more than four (4) NPs at one time. (BPC 2836.1)

### **Supervision of Medical Assistants**

Nurse Practitioners and Certified Nurse-Midwives may supervise Medical Assistants in "community clinics" or "free clinics" in accord with approved standardized procedures and in accord with those supportive services the Medical Assistant is authorized to perform (Business and Professions Code, Section 2069(a)(1); and Health and Safety Code, Section 1204(a) & (b).

### **Citation and Fine**

NPs, like all registered nurses, are subject to citation and fine for violation of the NPA. Citation and fines are a form of disciplinary action against the RN license and/or certificate. Examples of violations which have resulted in citation and fine are using the title "nurse practitioner" without being certified as a NP by the California BRN and failing to have standardized procedures when performing overlapping medical functions. NPs are encouraged to comply with all sections of the NPA to avoid discipline.

**References**

B&P Code, Section 2725 RN Scope of Practice, Section 2834 Nurse Practitioner, California Code of Regulation Section 1435 Citations and Fines, Section 1470 Standardized Procedure Guidelines, Section 1480 Standards for Nurse Practitioners.

**BRN Offices**

Sacramento Office: (916) 322-3350

*For more information, please visit the BRN's Web site at [www.rn.ca.gov](http://www.rn.ca.gov)*

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## Nurse Practitioners and Certified Nurse Midwives Treating Patients and their Partner or Partners for Sexually Transmitted Diseases

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### Legislation enacted during the 2005-2006 Session

Effective January 1, 2007, Assemble Bill 2280 (Leno) signed into law by Governor Arnold Schwarzenegger an act that amends Section 120582 of the Health and Safety Code:

- (a) Notwithstanding any other provision of law, a physician and surgeon who diagnoses a sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, in an individual patient may prescribe, dispense, furnish, or otherwise provide prescription antibiotic drugs to that patient's sexual partner or partners without examination of that patient's partner or partners. The department may adopt regulations to implement this section.
- (b) Notwithstanding any other provision of law, a nurse practitioner practicing pursuant to Section 2836.1 of the Business and Professions Code, a certified nurse-midwife pursuant to Section 2746.51 of the Business and Professions Code, and a physician assistant pursuant to Section 3502.1 of the Business and Professions Code may dispense, furnish, or otherwise provide a prescription antibiotic drug to the sexual partner or partners of a patient with a diagnosed sexually transmitted chlamydia, gonorrhea, or other sexually transmitted infection, as determined by the Department of Health Services, without examination of the patient's sexual partners.



**NURSE PRACTITIONERS AND NURSE MIDWIVES  
VEHICLES: PERSONS WITH DISABILITIES: VETERANS WITH DISABILITIES:  
PARKING PLACARDS**

Effective January 1, 2007

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Assembly Bill No. 2120 (Lui) Chaptered 116 approved by Governor Arnold Schwarzenegger, July 24, 2006 amend Section 5007, 9105, 22511.55 of the Vehicle Code. The amendments include nurse practitioners, nurse midwives and physician assistants as authorized health care professional that can sign the certificate substantiating the applicant's disability for the placard.

Existing law authorizes the Department of Motor Vehicles to issue distinguishing placards to persons with disabilities and veterans with disabilities and temporary distinguishing placards to temporary disabled persons, to be used for parking purposes. Prior to issuing the parking placard or temporary placard, the Department of Motor Vehicles requires the submission of a certificate, signed by an authorized health care professional, providing a full description substantiating the applicant's disability, unless the disability is readily observable and uncontested. Under existing law, the authorized health care professional that signs the certificate is required to retain information sufficient to substantiate the certificate, and make the information available to certain entities, upon request of the department.



## NURSE PRACTITIONERS COSIGN WORKERS' COMPENSATION CLAIMANT REPORT

Effective January 1, 2005

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Section 3209.10 to the Labor Code gives nurse practitioners the ability to cosign Doctor's First Report of Occupational Injury or Illness for a workers' compensation claim to receive time off from work for a period not to exceed three (3) calendar days if that authority is included in standardized procedures or protocols. The treating physician is required to sign the report and to make any determination of any temporary disability. **(AB 2919 (Ridley-Thomas) extends the operation of this provision indefinitely.)**

The Labor Code requires the physician treating a workers' compensation claimant for injuries to submit a report called "Doctor's First Report of Occupational Injury or Illness" to the employer within five (5) working days from the date of the initial examination. (AB 1194, Chapter 229 (Correa), Effective September 1, 2001 included nurse practitioners and physician assistants.)

The new sections of the Labor Code are as follows:

*SECTION 1. Section 3209.10 is added to the Labor Code, to read:*

*3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.*

*(b) The provision of subdivision (a) that requires the cosignature of the treating physician applies to this section only and it is not the intent of the Legislature that the requirement apply to any other section of law or to any other statute or regulation. Nothing in this section implies that a nurse practitioner or physician assistant is a physician as defined in Section 3209.3.*

*(c) This section shall remain in effect only until January 1, 2006, and on that date is repealed, unless a later enacted statute that is enacted before January 1, 2006, deletes or extends that date.*

*SEC. 2. The addition of Section 3209.10 to the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law and neither expands nor limits the scope of practice of nurse practitioners or physician assistants with regard to the delivery of care pursuant to Division 4 of the Labor Code.*

*SEC. 3. In enacting this act, the Legislature intends to abrogate the opinions expressed by the Administrative Director of the Division of Workers' Compensation as set forth in Minnie Martin v. Los Angeles Unified School District, AD No. 9786-4895, July 6, 1999, to the extent that it precluded a physician assistant from practicing within the scope of the protocol approved by the supervising physician and their lawful scope of practice.*



## **NURSE PRACTITIONER AND NURSE-MIDWIVES NEW AUTHORITY TO REQUEST AND SIGN FOR PHARMACEUTICAL SAMPLE MEDICATIONS**

**Effective August 24, 2002**

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Senate Bill 1558 (Figueroa), Chapter 263, was signed by Governor Gray Davis on August 24, 2002, to take effect immediately. The new law allows certified nurse practitioners and certified nurse-midwives **to sign for the request and receipt of complimentary samples of dangerous drugs and dangerous devices identified in their standardized procedure or protocol that have been approved by the physician.**

BPC Section 4061 Pharmacy law has been updated to: "However, a certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51 (Furnishing), a nurse practitioner who functions pursuant to a standardized procedure or protocol in Section 2836.1 (Furnishing), or protocol, or a physician assistant who functions pursuant to a protocol described in Section 3502.1, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedure, protocols, and practice agreements shall include specific approval by the physician. A review process, consistent with the requirements of Section 2725 (NPA, Guideline for Standardized Procedure (11)) or 3502.1 (physician assistant) of the complimentary samples requested and received by the NP, CNM, PA shall be defined within the standardized procedure, protocol, or practice agreement.

## NURSE PRACTITIONERS IN LONG - TERM CARE SETTINGS

Website: <http://leginfo.ca.gov/cgi-bin/waisgate?WaisDocID=49961416893+2+0+0&WaisAction=retrieve>

**Extracted from Welfare and Institutions Code**  
**Division 9**  
**Public Social Services**  
**Part 3**  
**Aid and Medical Assistance**  
**Chapter 7**  
**Basic Health Care**  
**Article 3**  
**Administration**

**§ 14111. Delegation of duties to nurse practitioners in long-term health care facility.**

(a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed by Medicare, a physician and surgeon may delegate any of the following to a nurse practitioner:

- (1) Alternating visits required by federal law and regulations with a physician and surgeon.
- (2) Any duties consistent with federal law and regulations within the scope of practice of nurse practitioners, so long as all of the following conditions are met:
  - (A) A physician and surgeon approves, in writing, the admission of the individual to the facility.
  - (B) The medical care of each resident is supervised by a physician and surgeon.
  - (C) A physician and surgeon performs the initial visit and alternate required visits.
- (b) This section does not authorize benefits not otherwise authorized by federal law or regulation.
- (c) All responsibilities delegated to a nurse practitioner pursuant to this section shall be performed under the supervision of the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.
- (d) No task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner.
- (e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and within the scope of practice of a nurse practitioner.

**14111.5.**

(a) As permitted by federal law or regulations, for health care services provided in a long-term health care facility that are reimbursed under this chapter, a nurse practitioner may, to the extent consistent with his or her scope of practice, perform any of the following tasks otherwise required of a physician and surgeon:

- (1) With respect to visits required by federal law or regulations, making alternating visits, or more frequent visits if the physician and surgeon is not available.
- (2) Any duty or task that is consistent with federal and state law or regulation within the scope of practice of nurse practitioners, so long as all of the following conditions are met:
  - (A) A physician and surgeon approves, in writing, the admission of the individual to the facility.

(B) The medical care of each resident is supervised by a physician and surgeon.

(C) A physician and surgeon performs the initial visit and alternate required visits.

(b) This section does not authorize benefits not otherwise authorized by federal or state law or regulation.

(c) All responsibilities undertaken by a nurse practitioner pursuant to this section shall be performed in collaboration with the physician and surgeon and pursuant to a standardized procedure among the physician and surgeon, nurse practitioner, and facility.

(d) Except as provided in subdivisions (a) to (c), inclusive, any task that is required by federal law or regulation to be performed personally by a physician may be delegated to a nurse practitioner who is not an employee of the long-term health care facility.

(e) Nothing in this section shall be construed as limiting the authority of a long-term health care facility to hire and employ nurse practitioners so long as that employment is consistent with federal law and with the scope of practice of a nurse practitioner.

### **Citation**

Alternate physician visits by NPs-Federal authorization found in the Omnibus Budget Reconciliation Act (OBRA) 1999 and Section 483.40 of the Federal Rules and Regulations (Federal Register, September 28, 1991) State authorization is found in California Welfare and Institutions Code, Section 14111 and 14111.5.

## NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS IN LONG - TERM CARE SETTINGS

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Nurse practitioners and clinical nurse specialists, certified by the Board of Registered Nursing, can provide comprehensive medical care to residents in long-term settings according to the standardized procedures co-developed with the physicians with whom they practice. Federal and state laws permit them to **provide alternate visits to residents in long-term care facilities after the physician makes the initial visit.** During these alternate visits they can:

- review the patient's total program of care
- write, sign, and date progress notes
- sign and date orders according to standardized procedures

Nurse practitioners and clinical nurse specialists providing these Medicare and Medi-Cal alternate visits are employed by the physician, clinic, or health plan with whom the standardized procedures are developed. They cannot be employed by the skilled nursing facility to perform alternate visits although they can be employed by or have a contract with skilled nursing facilities to provide other health-illness assessments and implement medical treatment plans per standardized procedures.

**Nurse Practitioners (NPs)** are registered nurses who have additional education and clinical experience in physical diagnosis, psychosocial assessment, and management of health-illness needs in a variety of practice settings. Nurse practitioners are educated in programs that meet the requirements of the Board of Registered Nursing. Most nurse practitioner programs grant a master's degree to their graduates.

**Clinical Nurse Specialists (CNSs)** are master's prepared registered nurses who participate in expert clinical practice, education, research, consultation, and clinical leadership.

Whenever NPs and CNSs perform functions or procedures which are considered to be the practice of medicine, i.e., diagnosing disease, prescribing medication, and penetrating or severing tissue, they are required to adhere to standardized procedures.

**Standardized procedures** are policies and procedures that are developed collaboratively by nursing, medicine, and administration in the organized health care setting where they will be used. This legal mechanism enables the practice of all competently prepared registered nurses to overlap the practice of medicine in California. Physician supervision is not required unless specified in a particular standardized procedure. Unless required under particular standardized procedures a physician's presence is not required when NPs and CNSs are providing their services although physician back up must be available. Physicians are not required by law to co-sign their orders although some third payment sources may require co-signing.

Some of the nursing functions NPs and CNSs commonly perform include obtaining a health history, conducting a physical examination, and ordering laboratory and radiological tests. Some of the medical functions they perform include determining a medical diagnosis, ordering medications, developing a medical treatment plan, and performing medical procedures such as lumbar puncture and bone marrow. NPs and CNSs must be identified by name in the standardized procedures.

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## Legal Citations

Nurse Practitioners - Business and Professions Code, Article 8, Sections 2834-2837, and California Code of Regulations, Article 8, Sections 1480-1485.

Clinical Nurse Specialists – Business and professions Code Section 2838.2

Standardized Procedures - Business and Professions Code, Chapter 6, Article 2, Section 2725(d), and California Code of Regulations, Article 7, Sections 1470-1474.

Alternate physician visits by NPs and CNSs - Federal authorization found in the Omnibus Budget Reconciliation Act (OBRA) 1990 and Section 483.40 of the Federal Rules and Regulations (Federal Register, September 28, 1991). State authorization is found in California Welfare and Institutions Code, Sections 14111 and 14111.5.